COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

REFUND REQUEST

CLINIC NAME AND ADDRESS	**STATE PROVIDER NUMBER**
	AMOUNT OF REFUND REQUESTED
NAME OF CLIENT	**CLIENT CASE NUMBER**
NAME OF PAYEE (IF DIFFERENT FROM CLIENT)	**COUNTY MISC. RECEIPT NUMBER AND DATE**
MAIL REFUND TO: **NAME** _____ **ADDRESS** _____ _____	**CLINIC CONTACT PERSON:** **NAME** _____ **TELEPHONE NUMBER** _____

APPROVED:

SIGNATURE _____ **TITLE** _____

REASON FOR REFUND

OTHER

ATTACH LEGIBLE COPIES OF ALL RECEIPTS, CANCELLED CHECKS, CORRESPONDENCE, ETC. TO THIS REFUND REQUEST FORM AND SUBMIT TO:

REVENUE GENERATION SECTION
FISCAL SERVICES DIVISION
550 S. VERMONT AVE., 8TH FLOOR
LOS ANGELES, CA 90020